HIT Standards Committee
Clinical Operations Workgroups – Task Force on Vocabulary

Tuesday, February 23, 2010, 9:00 a.m. to 4:30 p.m./Eastern Time
Omni Shoreham Hotel, 2500 Calvert Street, NW, Washington, DC

QUESTIONS FOR PANELISTS:

I. Purpose: Obtain public input on, and engage expert stakeholders in discussion of "rules of the road" for how vocabulary subsets and vocabulary value sets should be created, described, distributed, and maintained in order to facilitate meaningful use of electronic health records (EHRs).

II. Questions to be Addressed in Public Comments

With reference to the Vocabulary Task Force's definitions (in Attachment A), please respond to your choice of at least any four of the following questions about convenience subsets and/or value sets that are needed to facilitate meaningful use of EHRs. Be sure to specify which questions you are answering and to which category(ies) of subsets and value sets your comments apply.

1) Who should determine those that are needed?

   Subsets should be created to make it easy for users to do common things. Look at the common EHR workflows. Standards organizations should determine which coded terminologies are allowable for subset domains. However, standards organizations should not be involved in creating subsets.

   Mine usage data to confirm or augment consensus driven subsets. Then look to specialty organizations and groups within healthcare organizations to identify common problems, procedures and medications.

   Value sets should be created to encourage the collection of analyzable data. Value sets should be determined by organizations using the data for quality control and better patient care, for example AHRQ, and other national-based quality initiatives.

2) Who should produce them?

   Value sets/subsets should be created by organizations that are committed to long-term maintenance, responsiveness and experience with distribution and change control.

   Most healthcare organizations are not capable of creating their own subsets. Some are, but most would like out of the box subsets. However, many will

want to tweak them by either adding additional items or wanting different descriptions. Starter, out-of-the-box subsets can be created by any organization. However since most end-users/end-user organizations are not interested in maintaining these, it is imperative that the organization committed to provide the value sets/subsets be remunerated for keeping these subsets updated and in-sync with any standard code sets and respond to end-user requests in a timely fashion.

3) Who should review and approve them?

   Whereas the allowable code sets for the subsets should be determined by standards organizations, the actual content of the subsets can be reviewed and approved by specialty and healthcare delivery organizations.

   Value sets need more control than subsets. Controlling value sets is critical for understanding/aggregating captured data, while subsets are more site and user specific. Therefore, value sets need to be vetted through HL7. The determination of the coded terminologies to be used in subsets should be determined by standards organizations.

4) How should they be described, i.e., what is the minimum set of metadata needed?

   We believe there should be as much information as possible to encourage the proper use of the value sets/subsets. Metadata could include: source of terms; version; authors; effective dates; intended use with use case(s); contact information; description of creation process; and frequency of expected updates.

5) In what format(s) and via what mechanisms should they be distributed?

   Subsets/value sets need to be available in easy formats to consume, e.g., text files, MS Access, etc.; as well as standard UMLS and HL7 formats. It is critical for end-user organizations to be able to easily test drive so web-based demo sites need to be available.

   Distribution could be through either the NLM, for-profit and/or non-profit organizations as long as they are committed to ongoing distribution of updates.

6) How and how frequently should they be updated, and how should updates be coordinated?

   Updates should be based on code-set updates as well as the evolving needs of users and organizations. Therefore updates should be available as frequently as possible in order to be responsive to users and industry needs.

7) What support services would promote and facilitate their use?

   Easy ability to search online, determine coverage and intended use, and request new additions.

Possibly create a central site for the early creation of specialty based subsets. Users would be able to add/remove from starter set content and track their changes in order to eventually arrive at a virtual consensus. This will maximize the chance of early acceptance. Users should be able to share success stories and their specific use cases.

8) What best practices/lessons learned have you learned, or what problems have you learned to avoid, regarding vocabulary subset and value set creation, maintenance, dissemination, and support services?
    - Ease of deployment
    - Complete solution that requires a minimum of local responsibilities
    - Point of care deployment
    - Temporal versioning and change management
    - Context sensitive within the application (i.e. Problem list, History and assessment). Clear dependence on application developers to provide users with functionality to leverage the terminology solutions.
    - Users need for representational variability - meaning the many different ways to say the same thing. Different preferred display names for different contexts: e.g. problem list display vs. search results.
    - SNOMED® CT based subset creation is labor intensive.
9) Do you have other advice or comments on convenience subsets and/or value sets and their relationship to meaningful use?

    It is easy for a subset to grow stale if not properly maintained. Rather than have clinicians try and compensate at the point-of-care, usually through free-text edits, it is imperative that both the clinical coverage within the subset as well as the coding behind always be kept up to date.

    Another big challenge is reconciling the need for local variability with the need for standardization.
10) What must the federal government do or not do with regard to the above, and/or what role should the federal government play?

    Require EHR vendors to collect only codified data sets with minimal free text entry *and* continue to promote the interoperability of data between the various EHR systems.

Because we have only a limited time to conduct the hearing, we ask that you confine your oral remarks to **5 minutes**; Q&A with the Task Force members will follow. In order to maximize time at the hearing, we ask that you submit written comments on the above questions **no later than February 18, 2010**, so they can be reviewed by the Task Force members in advance.

There will be a broad solicitation of written public comments for this meeting. Approximately 10 people will be invited to provide in-person comments on February 23, 2010.